STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675572	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Rose Nursing and Rehab Center	1019 Holden St Glen Rose, TX 76043

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44722 Based observations, interviews, and record reviews, the facility failed to store all drugs and biologicals in locked compartments for 4 of 6 (SS Cart 1, SS Cart 2, SS Cart 3 and GV Cart) medication/treatment carts reviewed for label and storage of drugs and biologicals. The facility failed to ensure medication carts SS Cart 1 and SS Cart 2 were not left unlocked, unsecured, and unattended. The facility failed to ensure treatment carts, SS Cart 3 and GV Cart were not left unlocked, unsecured, and unattended. This failure could place residents at risk of having access to unauthorized medications, wound care and medical supplies leading to possible harm or drug diversions. Findings included: During an observation on 11/16/2024 at 12:15 PM and 12:30 PM SS Cart 1 and SS Cart 2 were parked against the wall with drawers facing the hallway , both carts were unlocked and were not in line of site of a staff. A resident was observed propelling himself in his wheelchair down the hall within arms length of SS Cart 1 and SS Cart 2. On the opposite hall SS Cart 3 was parked against the wall with the drawers facing the hallway unlocked and not in line of site of staff. SS Cart 1 and SS Cart 2 contained the following medications: Lasik, Levetiracetam, Losartan, Sertraline, Risperidone, Lisinopril, Tamsulosin, Baclofen, Trazadone, Mirtazapine, Fluoxetine, Fluphenazine, Divalproex, Metoprolol, Sucralfate, Gabapentin, Olanzapine, Bicalutamide, Eliquis, Rosuvastatin, Ranolazine, Buspar, Desmopressin, Albuterol, Mucinex, and Nasal Spray . SS Cart 3 contained the following items contained wound care creams (zinc oxide ointments, skin protectant ointment, and Vitamin A&D ointment) inhalers and eyedrops. During an interview on 11/16/2024 at 12:30 PM RN A stated she was not responsible for SS Cart 1 and SS Cart 2 and was not sure why the nurse did not secure the carts or where the nurse was at that time. RN A then secured the medications carts. RN A stated she was responsible for SS Cart 3 and she had gotten distracted by talking with a visitor and forgot to lock the cart. RN A stated residents could have been affected by the medication carts being left open by getting medications that were not theirs. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/16/2024 at 12:40 PM MA B stated she was responsible for SS Cart 1 and SS Cart 2, she stated she did not know why she had left the carts open. MA B stated medication and treatment carts should have been locked when she was not with them. MA B stated the affect on residents could have been possible overdose. MA B stated she was responsible to ensure carts were locked. MA B stated what led to the failure was it was Saturday and she had gotten in a hurry because she wanted to go home. During an observation on 11/16/2024 at 12:45 PM GV Cart was parked at the edge of the nurse's station with the drawers facing the residents in the secure unit. The GV Cart was unlocked, and the top drawer was slightly open, four residents were standing/sitting with arm's reach of the GV Cart. RN C was on the other side of the room with her back to Cart GV. During an interview on 11/16/2024 at 12:50 PM RN C stated the cart should have been locked. During an interview 11/21/2024 at 2:55 PM the DON stated her expectation was that medication and treatment carts should have been locked when unattended. The DON stated the nurse assigned to cart is responsible to ensure the cart was locked and the DON monitors. The DON stated the effect on residents could have been injury. The DON did not have a response to what led to failure of the medication carts being left unlocked. During an interview on 11/21/2024 at 3:15 PM the ADMN stated her expectation was that medication carts should have been locked when the cart was unattended. The ADMN stated the nurse who carried the keys to the cart was responsible to ensure the cart was secure, and the DON was responsible to monitor. The ADMN stated the effect on residents could have been residents advertently getting medication they were no supposed to. The ADMN stated what led to failure was oversight by the staff. Record Review of the facility's policy titled, Security of Medication Cart dated April 2007 revealed, The medication cart shall be secured during medication passes. 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with the doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurse's station or inside the medication room.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observations, interview, and record review the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurate for 2 (Resident #3 and Resident # 7) of 7 residents reviewed for resident records. The facility failed to ensure skin assessments were documented in medical record for Resident #3 and Resident # 7. This failure could place residents at risk of having errors in care and treatment. The Findings included: Resident #3 Record review of Resident #3's face sheet dated 11/21/2024 revealed a [AGE] year-old-male admitted on [DATE], with the following diagnosis Alzheimer's disease, heart disease, high blood pressure, and repeated falls. Record review of Resident #3's Admission MDS assessment dated [DATE] revealed; Section C- Cognitive Patterns: Resident #2 had a BIMS score of 0 (meaning severe cognitive impairment). Record review of Resident #3's care plan dated 10/25/2024 revealed Resident #2 required weekly skin inspections. Record review of Resident #3's electronic medical chart revealed no evidence of weekly skin inspections completed between his admission on 10/24/2024 and November 18, 2024. During an observation on interview on 11/21/2024 at 1:48 PM, Resident #3 had a rash to the back and both arms, and rash on the outer side of his legs and calves. RN A stated Resident #3 skin had been assessed, and benadryl had been added to his regime for itching on 11/10/24 and hospice had orders ointment for resident's skin. RN A stated she had assessed Resident #3's skin but had forgotten to complete the skin assessment because the treatment nurse had been completing the assessements and had been out on personal leave for several weeks. Resident #7 Record review of Resident #7's face sheet dated 11/21/2024 revealed [AGE] year-old-female admitted on [DATE] with the following diagnosis senile degeneration of brain, dementia, repeated falls, and Type 2 diabetes mellitus. Record review of Resident #7's Quarterly MDS assessment dated [DATE] revealed; Section C- Cognitive Patterns: Resident #1 had a BIMS score of 6(meaning severe cognitive impairment). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's care plan dated 10/19/2024 revealed Resident #1 required weekly skin inspections. Record review of Resident #7's electronic medical chart revealed no evidence of weekly skin inspections completed between 10/03/2024 and 11/06/2024. During an observation and interview on 11/21/2024 at 1:09 PM, Resident #7 had right elbow small circular scabbed wound and left shoulder blade abrasion. DON stated Resident #7 had a fall which led to the scabbed wound and shoulder blade abrasion. DON stated Resident #7 had been assessed and was treated for the abrasion. During an interview on 11/21/2024 at 12:45 PM, RN A stated every resident should have a skin assessment weekly. RN A stated skin assessments populate when needed to be completed and the nurse that was working that day was responsible to complete the skin assessment. RN A stated the skin assessment were not documented as expected in electronic medical record. RN A stated residents skin was assessed daily when providing incontinent care and during resident showers. During an interview on 11/21/2024 at 2:55 PM, the DON stated every resident was supposed to have had weekly skin assessments documented in their electronic chart. The DON stated skin assessments were triggered weekly for nursing staff to complete. The DON stated the treatment nurse was responsible to ensure they were completed, but she had been out for a family emergency and the nurses were supposed to have documented the assessments. The DON state residents skin was being assessed daily during incontinet care, showers and treatments. The DON stated she felt skin assessments were being done, they were just not documented in the medical chart. The DON was responsible to monitor to ensure they were being done. The DON stated what led to failure of skin assessments being undocumented was the treatment nurse was not in the building. During an interview on 11/21/2024 at 3:15 PM, the ADMN stated it was her expectation that skin assessments be completed and documented weekly for every resident. The ADMN stated the effect on residents having undocumented skin assessments could be potentially missing a skin condition that could have worsened or turned into an infection. The ADMN stated the DON was responsible to monitor to ensure skin assessments were being completed. The ADMN stated what led to failure of not skin assessments not being documented was the treatment nurse had been out, and some slipped thru the cracks. Record review of facility policy titled, Skin Assessment: New Admits or Resident Returning from Hospital Stay. Dated March 7, 2007, revealed It is the policy of this facility to establish a method whereby nursing can assess a resident's skin integrity to allow of appropriate interventions be initiated in a timely manner.